VERMONT

DVHA CLINICAL UNIT

DEPT OF VERMONT
HEALTH ACCESS
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Telephone: (802) 879-5903
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VERMONT MEDICAID PRE-PROCEDURE REQUEST FORM

Date of Request: _____

Date, if Procedure has been scheduled: _____ ☐ N/A: Procedure has not been scheduled

Procedure is: ☐ Elective ☐ Urgent ☐ Emergent (Does not require prior authorization).

Setting where procedure will be performed: ☐ Hospital Outpatient ☐ Hospital Inpatient

Patient Name: (last) _____ (first) _____

Medicaid ID Number: _____ Date of birth: _____ Gender: M F (please circle)

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Provider Information

Requesting Provider Name: _____ VT. Medicaid Provider Number: _____

Requesting Provider NPI: _____ Taxonomy: _____

Provider Address: _____

Office Contact Person: _____ Telephone Number: _____ Fax: _____

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Facility Information

Facility Name: _____ VT. Medicaid Provider Number: _____

Facility NPI: _____ Taxonomy: _____

Facility Address: _____

Office Contact Person: _____ Telephone Number: _____ Fax: _____

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Procedure(s) Requested

Procedure: _____ Diagnosis: _____ICD-9 Code: _____

ICD-9 Procedure Code: _____ Diagnosis: _____ICD-9 Code: _____

CPT Procedure Code: _____ Diagnosis: _____ICD-9 Code_____

Procedure: _____ Diagnosis: _____ICD-9 Code: _____

ICD-9 Procedure Code: _____ Diagnosis: _____ICD-9 Code: _____

CPT Procedure Code: _____ Diagnosis: _____ICD-9 Code_____

Procedure: _____ Diagnosis: _____ICD-9 Code: _____

ICD-9 Procedure Code: _____ Diagnosis: _____ICD-9 Code: _____

CPT Procedure Code: _____ Diagnosis: _____ICD-9 Code_____

Patient Medicaid Number: _____

Medical Information – All Procedures

Provide convincing information to justify each procedure on page 1.

Have any other related procedures been done previously for the same problem or condition?
No ☐ Yes ☐ If yes, when: Month _____ Year _____ Specify results and/or attach reports.

Provide pertinent medical information and rationale for the procedure(s) being requested. Include all conservative treatments/ interventions and the results/outcomes.

Supporting Documentation (History & Physical, prior surgery, consultations, photos, if applicable, etc.) N/A ☐

- Date: _____ Treatment: _____

  Results: _____
- Date: _____ Treatment: _____

  Results: _____
- Date: _____ Treatment: _____

  Results: _____

If this Prior Authorization request is for a Hysterectomy or Bariatric Surgery, please complete the appropriate attached page.

X Signature of Requesting Provider: _____ Date: _____

Patient Medicaid Number: _____

Hysterectomy

Hysterectomy: Attach a copy of the latest **HISTORY and PHYSICAL.** Complete the following if the information is not included.

1. Medication Management (OCP, GnRH agonists, NSAIDS, Iron, etc.): N/A ☐

- Name: _____ Dose:_____ Duration, including dates: _____

  Results: _____

- Name: _____ Dose:_____ Duration, including dates: _____

  Results: _____

2. Diagnostic Test/Surgery/Procedures/Imaging: N/A ☐

- Date: _____ Name: _____

  Results: _____

- Date: _____ Name: _____

  Results: _____

3. Pathology Reports (Labs – TSH, PAP): N/A ☐

- Date: _____ Name: _____

  Results: _____

- Date: _____ Name: _____

  Results: _____

4. Sterilization **Yes** ☐ **No** ☐ **If yes, Date:** _____

5. Future Childbearing desired? **Yes** ☐ **No** ☐

COMMENTS:

X Signature of Requesting Provider: _____ Date: _____

MEDICAL RECORDS MAY BE SUBJECT TO AN DVHA MEDICAL RECORD RETRO REVIEW.

Patient Medicaid Number: _____

Bariatric Surgery

1. **Current** Weight: _____ Height: _____ BMI: _____ Age: _____

2. How long has the patient been obese? Less then 5 years ☐ More than 5 years ☐

3. History of current substance abuse? Yes ☐ No ☐

If yes, specify: _____

_____

_____

4. List impacting medical and functional factors/co-morbidities: _____

_____

_____

5. TSH normal: Yes ☐ No ☐ If yes, Date test performed: _____

6. Has the patient been on a physician/dietician supervised diet program for six months? Yes ☐ No ☐

7. Does the patient understand surgical risk and post procedure compliance and follow-up requirements? Yes ☐ No ☐

8. What is the plan for post-surgical follow-up? _____

_____

COMMENTS:

X Signature of Requesting Provider: _____ Date: _____

MEDICAL RECORDS MAY BE SUBJECT TO A DVHA MEDICAL RECORD RETRO REVIEW.